

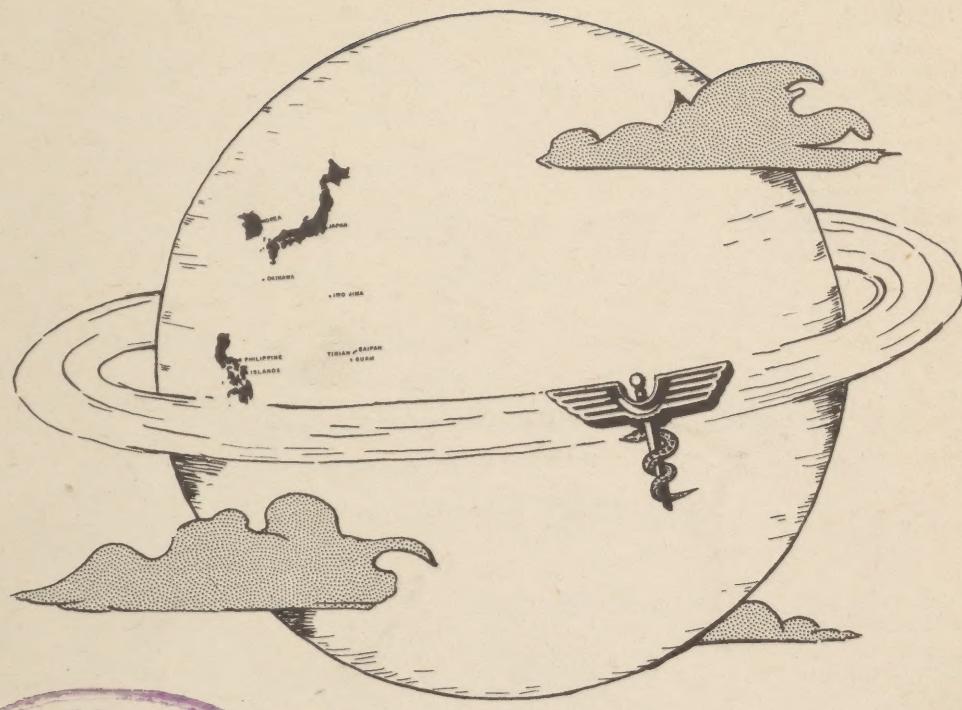
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DOCUMENT SECTION

MED SEC GHQ FEC

VOL V NO 11
1 NOV 1950



ARMY
MEDICAL
DEC 18 1950

A FAR EAST PERIODICAL OF MEDICAL DEPARTMENT INFORMATION

SURGEON'S CIRCULAR LETTER

RESTRICTED

RESTRICTED

Venereal Diseases: The venereal disease rate for the FEC decreased from 112 in August to 96 for September. The explanation of this decrease is Korea's dominating strength with a low incidence rate for these diseases. Japan's venereal disease rate decreased from 168 in August to 145 in September. Korea's rate increased from 14 to 33. MARBO's rate remained the same, 13. PHILCOM (AF)'s rate decreased from 62 to 60, and RYCOM's rate increased from 199 to 205.

Deaths: There were 381 deaths reported by hospital, and dispensary in the FEC during September. Of these, 280 occurred among battle casualty admissions; 36 resulted from diseases, and 65 from nonbattle injuries.

Evacuation:

Tabulated below are the number of patients evacuated from the major commands to the ZI during the 5-report weeks in September and the number of patients awaiting evacuation as of 29 September 1950:

	BY AIR	BY WATER	TOTAL	PNTS AWAITING EVACUATION
JAPAN	3,626	1,388	5,014*	350
MARBO	12	1	13	1
PHILCOM(AF)	20	1	21	0
RYCOM	48	14	62	26
FEC	3,706	1,404	5,110	377

(* 4023 patients originated from Korea.)

Hospitalization:

The bed status as of 29 September 1950 was as follows:

	Bed Capacity		Operating Beds	Beds Occupd.	% Normal Bed Capacity Occupd.	% of Operating Beds Occupd.
	Normal	Mobilization				
JAPAN	5,752	8,100	8,100	7,550	131	93
KOREA	1,580		2,156	925	59	43
MARBO	200	200	200	93	47	47
PHILCOM(AF)	1,919	2,332	601	322	17	54
RYCOM	250	300	250	168	67	67
FEC	9,701	10,932	11,307	9,058	93	80

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FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NO. 11

1 November 1950

PART IADMINISTRATIVE

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I. Organization of the Medical Section

Arrival in the Medical Section, GHQ, FEC: Colonel Arvo T. Thompson, VC, formerly assigned to the Medical Section, Japan Logistical Command, has assumed the duty of Veterinary Consultant to the Chief Surgeon, Far East Command.

II. Surgeon General Praised Korean Medical Care - DA SGO, Technical Information Office, Wash, D. C.

After an exhaustive survey of the Medical Service in Korea and the Far East Command during September and October, Major General Raymond W. Bliss, the Surgeon General, Department of the Army, stated that a truly remarkable record was being accomplished in the protection of health and saving of life by members of the military medical services in the Far East.

General Bliss stated that personal observation of the medical work being accomplished has confirmed the fact that medical care for the fighting men has achieved a superior standard.

He pointed out that in World War II, three out of every four wounded men who were admitted to hospital, were returned to duty. As outstanding as this record was, present indications are that this record will be surpassed, unless there are unexpected developments as yet unforeseen in the Korean campaign. In one evacuation hospital in Korea, General Bliss stated that 18,000 men have been admitted for treatment during a three-month period. Of those 18,000, only 40 lives were lost.

Even in the forward areas where the mobile surgical hospital initially received seriously wounded casualties under the most dangerous and trying conditions, less than one death for every 100 admissions has been recorded. Admissions for disease in Korea were only slightly higher than for wounds and non-battle injuries.

The disease record there becomes almost spectacular, he said, when one remembers that

Korea has been the point of origin of some of the most extensive epidemics the world has ever known, including those of cholera, plague, dysentery, typhus and typhoid fever.

He pointed out that although our soldiers frequently were forced to spend long hours, even days, in rice paddies fertilized with human excreta where the water is highly contaminated, the number of cases of dysentery has been held at a minimum. General Bliss said much of the campaign has been fought through the peak season for malaria; even so, the number of cases among our soldiers has been very small. He pointed out that small-pox, an ever real and ever menacing danger in Korea, existed among American civilians evacuated from Korea when the Red attack was launched, yet there has been no single case in any member of our Armed Forces, or any case of tetanus, cholera, typhoid fever, hepatitis, and all intestinal or respiratory diseases have been lower than anticipated.

General Bliss said the result obtained to date had been brought about by the Army's concept of what he described as "total" medicine. In explaining "total" medicine, he outlined four basic principles which had made the superb medical record in the Far East Command possible.

First, he said that planning and administration, as well as the medical logistical operations had been carried out in a brilliant manner.

Second essential element was the Army's preventive medicine program which had succeeded admirably in overcoming the dangers to health inherent in the Korean campaign.

Third element was the high level of professional accomplishment by medical personnel in Korea in saving life and caring for the sick and wounded. These accomplishments, he said, are a reflection of the outstanding contribution made by the Army's residency training program. In respect to this third point, General Bliss asserted that physicians, nurses and others were working around the clock for periods as long as 36 to 48 hours. Shortages of doctors and other medical personnel in the Far East have made such gruelling hours necessary, he said, in order to insure that every soldier receives the medical treatment he needs.

His fourth item was the laboratory and research phase of medicine in the Far East Command which had been outstanding in its support of medical activities.

General Bliss believed that the fine performance by the Medical Service in Korea has brought home the fact to those who were able to witness events firsthand that the professional standards of the Army, as well as the other Armed Forces are among the highest in the world. He stated these views were borne out by outstanding civilian physicians and educators who had opportunity to observe the medical work being done in the Far East as consultants from his office.

III. Awards to Army Medical Service Personnel



The following additional Army Medical Service personnel have been awarded the Air Medal, Silver and Bronze Star Medals for exceptional bravery in face of the enemy and meritorious service in the Korean situation.

Lt Fenner H. Whittley, MSC, Air Medal
 Capt Charles K. Gardiner, MSC, SS
 Capt William C. Hedberg, MC, SS
 Capt Tom A. Simmons, MSC, SS
 Cpl James T. Belcher, AMS, SS
 Cpl Harold J. Davidson, AMS, SS (Posthumously)
 Cpl Emmanuel R. Messier, AMS, SS
 Pfc Bradley H. Daniels, AMS, SS
 Pfc Carl N. Heckart, AMS, SS
 Pvt James L. Brown, AMS, SS
 Maj Louis N. Altshuler, MC, BSM
 Capt Jesse W. Kicklighter, MSC, BSM
 Capt Robert J. Roglas, MSC, BSM
 Capt Robert E. Stevens, MC, BSM
 1st Lt Robert G. Brown, MC, BSM
 1st Lt Jackie E. Edgar, MSC, BSM

1st Lt Robert W. Lower, MSC, BSM
 1st Lt Allen T. Thompson, MSC, BSM
 M/Sgt Roy A. Bowler, AMS, BSM
 Sgt 1/c Evert B. Crow, AMS, BSM
 Sgt 1/c Charles H. Frederick, AMS, BSM
 Sgt 1/c Edward A. Peters, AMS, BSM
 Sgt M. L. Brauen, AMS, BSM
 Sgt Earl L. Burrow, AMS, BSM
 Sgt Howard L. Cassidy, AMS, BSM
 Sgt Archie Cone, AMS, BSM
 Sgt Fred Contreras, AMS, BSM
 Sgt Ralph R. Everett, AMS, BSM
 Sgt Donald F. Friedrick, AMS, BSM
 Sgt Raymond J. Huber, AMS, BSM
 Sgt Harold Krause, AMS, BSM
 Sgt William Kriegsman, AMS, BSM

Sgt Daniel F. Ledbetter, AMS, BSM
 Sgt John B. McDowell, AMS, BSM
 Sgt Bert H. Mosier, Jr., AMS, BSM
 Sgt Maultry Rogers, AMS, BSM
 Sgt William J. Sanderfer, AMS, BSM
 Sgt Ralph J. Scholz, AMS, BSM
 Sgt Julius H. Schreiner, AMS, BSM
 Sgt Merl S. Stanley, AMS, BSM
 Sgt Jeremiah J. Sullivan, AMS, BSM
 Sgt John W. Westbrook, AMS, BSM
 Cpl Glenn E. Bunker, AMS, BSM
 Cpl Thomas L. Beachmen, AMS, BSM
 Cpl Dale R. Bolner, AMS, BSM
 Cpl Vincent G. Boody, AMS, BSM
 Cpl John A. Clement, AMS, BSM
 Cpl Charles W. Damerson, AMS, BSM
 Cpl Fidel Flores, AMS, BSM
 Cpl John D. Graves, AMS, BSM
 Cpl Victor Hay, AMS, BSM
 Cpl Donald H. Ingle, AMS, BSM
 Cpl David Marmolejo, AMS, BSM
 Cpl William E. McCullough, AMS, BSM
 Cpl Terry Mullen, AMS, BSM
 Cpl Carl L. Page, AMS, BSM
 Cpl William C. Roberts, AMS, BSM
 Cpl Floretion Romano, AMS, BSM "V" Device
 Cpl Edward Scott, AMS, BSM
 Cpl Arthur H. Sexton, AMS, BSM
 Cpl Norman Starr, AMS, BSM
 Cpl Gene E. Timmerman, AMS, BSM

Cpl Harold C. Washington, AMS, BSM
 Cpl Balis E. Whitaker, AMS, BSM
 Cpl Robert H. Worthington, AMS, BSM
 Pfc Frank L. Coble, AMS, BSM
 Pfc Billy R. Cook, AMS, BSM
 Pfc Carl L. Copeland, AMS, BSM "V" Device
 Pfc James F. Dingly, AMS, BSM
 Pfc Richard M. Doby, AMS, BSM
 Pfc Raymond L. Dowis, AMS, BSM
 Pfc Jesus L. Espindola, AMS, BSM
 Pfc George H. Finstad, AMS, BSM
 Pfc Henry E. Foster, AMS, BSM
 Pfc Jose Garcia, Jr., AMS, BSM
 Pfc Anthony Girdano, AMS, BSM
 Pfc Pius Hoffart, AMS, BSM
 Pfc Mansfield Johnson, AMS, BSM
 Pfc Joseph A. Mason, AMS, BSM
 Pfc Donald M. McKee, AMS, BSM
 Pfc Paul R. Pafchek, AMS, BSM
 Pfc Richard A. Roberts, AMS, BSM
 Pfc Frank J. Schwegler, AMS, BSM
 Pfc James A. Williams, Jr., AMS, BSM
 Pfc Connie Williamson, AMS, BSM
 Pvt Robert N. Bacon, AMS, BSM
 Pvt W. D. Fisher, AMS, BSM
 Pvt Victor L. Mantaya, AMS, BSM
 Pvt Maurice N. McClellan, AMS, BSM
 Pvt Gerald J. Miceli, AMS, BSM
 Pvt John H. F. Teal, AMS, BSM

IV. Medical Expert Consultant Visits Far East Command

Dr. Howard D. Fabing, Neuropsychiatrist, civilian consultant to The Surgeon General, has arrived in the Far East Command for an inspection tour of medical installations for a period of approximately 30 days. Dr. Fabing, who has had extensive training in the treatment and handling of psychiatric casualties in the European theater in World War II, is especially interested in observing the treatment provided that type patient in Army medical installations.

V. Maintenance of Syphilis Registers - Reference C-6, AR 40-210, 16 Jan 48



It is essential that all personnel charged with the responsibility of the initiation, maintenance and closing of the Syphilis Register take the necessary steps to insure that a Syphilis Register is initiated and that it contains all pertinent information available, so as to make it a valuable reference for the proper follow-up treatment of the patient concerned. Furthermore it is equally important that the information contained therein be set forth in a legible, concise and intelligible manner. Whenever possible, the register will be typed, but in the event this is not possible a legible script or printing may be used. Lead pencil entries are not acceptable.

Medical Care: Every known case of syphilis will be promptly treated. Individuals in the infectious stages of syphilis may be either hospitalized or treated on an out-patient or duty status. Commanding officers will assure that all cases treated without hospitalization are restricted to the post until noninfectious. Current rosters of those undergoing treatment and/or observation will be kept, both by the organization commander and by the surgeon, until his register is closed.

Initiation: The medical officer making the diagnosis will initiate a Syphilis Register (WD AGO Form 8-114) for each person who is discovered to have syphilis.

Identification: Identification data of the individual will be entered in the proper spaces provided at the top of page one, including the complete diagnosis and date such diagnosis is made. All date entries will conform to the provisions of paragraph 11, AR 340-15. All entries made will be signed by the medical officer making such entries.

History and Physical Findings: A careful history and physical examination will be made and all pertinent information will be recorded. All spaces provided should be adequately complete; a brief summary of any significant data relative to the history and a thorough description of any positive findings on which a diagnosis is based. All dark field findings, serologic results and spinal fluid findings must be recorded, dated and signed.

Treatment: Treatment administered will be fully described by giving complete details as to the dates treatment was started and completed, the total dosage, the interval, the method of administration, reactions, if any, and the patient's immediate response. In the event of retreatment, an explanation should be made as to why the patient is being retreated, stating whether it is a relapse or reinfection, the manifestations, and giving a full account of the retreatment administered.

Maintenance: The register will be continued until the case is closed for any one of the following reasons:

- Treatment and follow-up completed, result satisfactory.
- Patient discharged from the service.
- Patient deserted or otherwise lost to military control.
- Death of a patient.

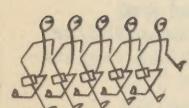
The period during which these follow-up examinations will be performed prior to closure of register will conform to current technical directives.

Transfers: The transfer of Syphilis Registers is a command responsibility. When an individual under treatment or observation for syphilis is transferred to another organization or station, the commanding officer of the patient will be responsible for procuring the Syphilis Register from the treating agency and inclosing the register with the individual's service record and allied papers for transfer to his new organization or station. The forwarding indorsement on page 11 of the Syphilis Register will be prepared and signed by the commanding officer of the transferring unit each time a transfer is made and the commanding officer of the receiving unit will immediately upon receipt of the register forward it to the hospital or dispensary responsible for providing medical care to the organization.

Closure: When syphilis registers are closed for any of the reasons in "Maintenance" above, the officer making the closure will sign his name in the space provided on page one of the register and forward it immediately through medical channels to The Chief Surgeon, General Headquarters, Far East Command, with a letter of transmittal in quadruplicate. The Medical Section, General Headquarters, Far East Command, will forward the Syphilis Register to The Surgeon General with the original letter of transmittal in triplicate.

The above instructions in no way alter existing regulations and directives for the initiation and maintenance of Patients Record of Syphilis Treatment (WD AGO Form 8-115) under the provisions of paragraph 24d, AR 40-210. Compliance with paragraph 24, C6, AR 40-210 and TB MED 230, 6 January 1949, concerning the maintenance of Syphilis Registers and Management of Venereal Diseases is requested of all agencies forwarding Syphilis Registers to this headquarters for submission to The Surgeon General.

VI. Residency Training



For Medical Corps officers who are interested in applying for a residency, the following letter from The Surgeon General's Office to a Medical Corps officer currently serving in the Far East Command is published herein as a matter of information.

"1. This is to acknowledge your letter inquiring about residency training on your return from overseas..... Your original application has been withdrawn from your 201 file and placed with other applications that are to be considered upon the return of officers from overseas.

"2. Just at present it would be hard to say just when you will return, but I believe that you will probably have to complete a normal tour of foreign service in the Far East Command. This should bring you back some time late in 1952. Actually it would be to your advantage to do that for two reasons. First, the spaces for residency training for 1 January and 1 July 1951 are being reserved for the officers who were in the program but had to be relieved for temporary duty overseas. Second, you will gain some valuable experience in the field which will be of tremendous aid to you, not only during your residency, but throughout your military career."

VII. Reestablishment of Battalion Surgeon Assistant Course Considered

Information has been received from the Brooke Army Medical Center, Ft. Sam Houston, Texas, that consideration is being given to the reestablishment of a Battalion Surgeon Assistant Course. This course will be similar to that conducted during World War II. It is designed primarily to prepare lieutenants of the Medical Service Corps for duty with tactical medical units.

VIII. New Surgical Dressings Developed by Army Medical Service's Research and Development Board - DA SGO, Technical Information Office, Washington 25, D. C.



Two new oversized dressings, another step in Army medical advancement, have been developed by the Army Medical Service's Research and Development Board.

The new dressings consist of an inside or wound layer of highly absorbent fine mesh gauze, which may be treated to reduce irritation to wounds; and an outside, non-absorbent layer that prevents bacteria from entering the wound or burn. These qualities will permit the dressings to be worn for as long as 14 days, whereas present type burn dressings must be changed every day or two, depending upon the degree of the burn.

Smallest of the dressings, 19 by 34 inches, are about five times larger than the largest size now in use. The larger one, for more extensive burns or wounds, is 34 by 45 inches. These dressings were developed for use during the first aid phase of treatment to give the casualty every benefit of Army medical research possible, and to improve his chances of reaching a hospital for definitive treatment.

These dressings will offer much greater protection to a large burned area, such as a tanker might sustain when his tank is hit, or a soldier might receive from the burst of a high explosive bomb. In the case of severely burned extremities, a dressing can be wrapped around the affected part.

Wounds resulting from blast, where small particles of loose debris have entered the skin over a considerable area, may also be treated with the dressings. In the event of an atomic bomb burst, both dressings would be invaluable.

The smaller dressing also may be used as an arm splint when tightly applied. The dressings are packed in a plastic bag that is resistant to water, moisture, and heat.

IX. Medical Follow-Up Card

Medical officers of the Far East Command are reminded that SR 40-590-60, AFR 160-47, makes provisions for follow-up information on patients evacuated to higher echelons in the command and to the zone of the interior. For correct procedure for initiation of this form, see the aforementioned regulations.

PATIENT: (Last name - First name - Middle initial)		GRADE	SERVICE NO.	REPORTS CONTROL SYMBOL MED-3
CONDITION ON ARRIVAL AT HOSPITAL				
DIAGNOSIS				
SUBSEQUENT THERAPY AND PROGRESS				
DISPOSITION: <input type="checkbox"/> PROBABLE <input type="checkbox"/> FINAL				
REMARKS OR RECOMMENDATIONS				
DATE	SIGNATURE AND GRADE		HOSPITAL	SERVICE
To be completed and returned to the issuing Medical Officer after definite conclusions have been reached as to diagnosis, therapy, and disposition, or at the expiration of 60 days. When mailing, use window envelope.				
NME 1 APR 48		MEDICAL FOLLOW-UP CARD		16-4800-1

MODEL

X. Report of Medical History, Standard Form 89

The revised Standard Form 89, Report of Medical History, is reproduced below for the information of all personnel concerned.

XI. Medical Company, 21st Infantry Regiment, 24th Division - Lt Herbert Hinricks, MSC



Since this is being written two months after my evacuation from Korea, my memory for exact dates and certain pertinent information may be somewhat faulty. However, it is not my intent to present a chronologically correct report, but rather to submit from my experiences in the field, certain recommendations which I believe are worthy of consideration.

On 11 August 1949, I was assigned as Medical Assistant in the Medical Company, 21st Infantry Regiment, 24th Division. I subsequently learned from other MSC officers after my arrival in Korea that I was more fortunate than most in that I knew my men, having trained with them for almost a year before the Korean conflict. This brings me to my first recommendation.

I strongly feel that Medical Companies in Infantry Regiments should always be kept up to T/O&E strength, but the 21st for the most part of the year before 25 June 1950 had only two MSC officers whereas they were authorized six. To the best of my knowledge, the Medical Company of the 21st was the only unit understrength in officers. This is unfair to both officers and men. We went into Korea on the 4th of July with three officers. On 11 July, one MSC officer (Captain Douglas Anderson) was listed as missing and it wasn't until about the first part of August that we received our first replacement and he was wounded his second day of action. From then, until the latter part of August, through some of the worst fighting of the Korean war, the entire responsibility of our Medical Company fell upon Lt Raymond Adams and myself.

However, to get back to our garrison training - a medical company on a post, camp, or station, should be concerned only with training in its primary mission, that is, medical support of an infantry regiment. Our medical company was responsible for the medical care of all military personnel and their dependents and since the nearest hospital was 35 miles away (118th Station Hospital) it was necessary for us to operate a 10-bed dispensary type hospital requiring at least 40 men full-time on a 24-hour basis plus the one doctor we had and an MSC officer. Not until after the alert did we organize our Collecting Platoon, and these men, with no previous training had to set up in Chochiwon, Korea, where casualties were received almost immediately. Under the supervision of our Regimental Surgeon, the men did a wonderful job, sometimes receiving as high as 200 casualties in a single day and I feel they continued to do an outstanding job through the remaining time I was with the unit.

After the withdrawal from the Chochiwon, Taejon and Yongdang areas, it became necessary to reorganize the 3rd Battalion Medical Platoon. For the type of terrain in Korea and especially along the Naktong river front, I made several changes from the SOP. For each line company, I assigned 8 litter bearers, 4 aidmen, 1 Sgt and a litter jeep with driver. I organized two blood plasma teams and only kept about 4 men in the Battalion Aid Station itself. The litter bearers were volunteer South Korean civilians first and later on ROK soldiers. I effected this organization from lessons learned earlier in the campaign when it was sometimes necessary to leave wounded behind. The heavy weapons company had two aidmen and nothing else unless the situation called for it.

I think the most significant idea of the above paragraph is that I concentrated on medical support of an infantry battalion more on a company level.

Early in the campaign, evacuation from the company front was not always successful, but from the Battalion Aid Station to Collecting and Clearing it was always good. North of Chochiwon it was necessary for the litter jeep drivers to drive time and again through concentrated enemy machine gun fire in order to get wounded out. I feel that these drivers were the real heroes in our company. From our experience, I do not believe 3 litter jeeps are enough per battalion. If all line companies are engaged with the enemy and we lose one jeep, one company will suffer until a replacement can be secured. I feel that we should have at least two more in a battalion or a total of six more in the T/O for the medical company. I did not hesitate to keep at least two large ambulances at the Battalion Aid Station from the Medical Battalion. As with the jeep drivers, these ambulance drivers did a wonderful job and our Regiment did not lose an ambulance nor were any of the drivers wounded.

From Collecting to Clearing, several methods of evacuation were used. Early at Chochiwon we used a self-propelled rail car which we called a "Doodlebug." After our withdrawal from there we used medical battalion ambulances and rail. Sometimes we would load walking wounded on any available transportation going to the rear. Incidentally, the ROK Army used this method exclusively. Air evacuation problems varied. I believe the Regimental Surgeon received permission to use helicopter for serious abdominal and chest wounds about the time I was evacuated.

In the matter of evacuation, we learned that the site of the medical installations was of utmost importance. In selecting the site for either the Collecting Station or Battalion Aid Station, I never paid much attention to the Regiment Headquarters or Battalion Headquarters perimeter, yet I think our selection of sites excelled anything I saw. At one time when other medical installations were cut off by road blocks our Collecting Station received all casualties from Chochiwon to Hyonpung, a front of over 20 miles along the Naktong river. At the same time we split our Collecting Station moving all our heavy trucks and equipment back, yet leaving an Aid Station capable of taking care of the situation. In this manner if our station were overrun, most of our equipment would be safe and the items left could easily be destroyed before we "dug out" in the hills. We received casualties at this skeleton station directly from the line from units more than 12 miles away since we were the first Aid Station to give emergency medical treatment. Later when this line became more secure, we again consolidated our equipment.

Our supply activities were always good mainly through the efforts of Captain Podsiadly, former Division Medical Supply officer and later Medical Battalion S-4. We ordered and received most of our supplies by using ambulances which went to the rear with patients. However, when the situation permitted, I would send my supply sergeant back with a truck, not only to pick up an order but to discuss the supply situation with depot personnel and to get any items not previously available. Our liaison with Regiment S-4 was good and any problems we had with that office were worked out to the satisfaction of all concerned. Our vehicles held up remarkably well considering the roads in Korea and the loads they carried. I feel that a good motor sergeant is most important in a Medical Company and we were fortunate in having a very good one.

At this point I want to mention the fact that most Battalion Surgeons and MSC officers believed that the Medical Field Set No. 2 (9-274-320) is outdated. There are items in those chests that we have been taught NOT to use. One supposedly new chest that was received contained no penicillin yet there were 3 or 4 cans of the sulfanilamides. As I remember, the basic issue of morphine tartrate syrettes for the No. 2 Field Set is 10 packages of 5 each per package. With heavy casualties coming in such a quantity would not last two hours. I think the quantity of syrettes in these sets should be increased to 60 packages. I also think that the Medical Kit, Individual (9-274-960), should contain morphine syrettes. If an aidman isn't qualified to use morphine in the field, he isn't qualified for the duty of aidman.

Again I'll say that the status of our supply was good. I don't ever remember being in short supply of bandages, plasma or morphine.

In conclusion I wish to state that my recommendations that medical companies be trained in their primary mission - medical support of an infantry regiment; that a more effective organization be evolved for processing casualties at a company level; that more litter jeeps be authorized; and that a reevaluation be made of items in the No. 2 Medical Field Set, are based on experiences gained from a "delaying action" war - the toughest kind of war there is for medical personnel. We had an MC and MSC officer listed as missing in action; an MSC officer who was seriously wounded and never returned to duty, and of the group of 118 with whom we arrived in Korea, only 50 EM remained at the time of my evacuation from Korea.

XII. Recent Department of the Army and FEC Publications



- AR 40-695, 18 Sep 50: Medical Service - Administration of Army and Navy General Hospital
- AR 40-508, 21 Sep 50, C-1: Medical Service - Medical Care for Nationals of Foreign Governments in Army Medical Treatment Facilities
- AR 40-441, 25 Sep 50: Joint Utilization of Armed Forces Medical Laboratories and Epidemic Disease Control Units
- AR 40-20, 3 Oct 50, C-3: Medical Department - ANC - General Provisions
- AR 40-920, 4 Oct 50: Medical Service - Veterinary Laboratories
- AR 40-600, 16 Oct 50: Medical Service - Medical Treatment Facilities
- DA CIR 55, 2 Oct 50: Sec XI - Sulfanilamide - First Aid Packets
- SR 600-37-1, 15 Sep 50, C-1: Personnel - Women's Army Uniform
- SR 135-210-1, 19 Sep 50, C-1: Civilian Components - Entry on Extended Active Duty
- SR 40-590-43, 19 Sep 50, C-2: Medical Service - Admission and Treatment of Merchant Seamen in Medical Facilities of DA Outside Continental U. S.
- SR 40-530-10, 21 Sep 50, C-2: Medical Service - Hospitalization in Army Medical Facilities in Continental U. S. of Nonmilitary Personnel Enroute to or from Overseas
- SR 40-590-40, 22 Sep 50, C-1: Medical Service - Report of Treatment of Pay Patients (RCS MED-45)
- SR 40-590-49, 22 Sep 50, C-1: Medical Service - Admission and Treatment of Civilian Employees of Cost-Plus-A-Fixed-Fee Contractors of DA in Medical Treatment Facilities of Department outside Continental U. S.
- SR 700-70-20, 3 Oct 50: Supplies and Equipment - Responsibility for Hospital and Similar Medical Assemblages
- SR 40-920-1, 4 Oct 50: Medical Service - Veterinary Laboratory Service
- SR 140-105-6, 12 Oct 50: ORC - Appointment in Army Medical Service Sections
- GO 28, 24 Aug 50: Sec VI - Named General Hospitals - Redesignated
- GO 30, 12 Sep 50: Sec VI - Changes in Designation of Army Medical Treatment Facilities - GO 21, '50, amended
- DA PAMPHLET 8-5, 13 Sep 50, C-2: Procurement of Spectacles for Military and other Authorized Personnel
- TC 12, 11 Sep 50: Defense Against Biological Warfare
- T/O&E 8-567, 26 Jun 50: Station Hospital, 750-Bed, Communications Zone
- T/O&E 8-17 N, 29 Aug 50, C-1: Ambulance Company, Medical Battalion

T/O&E 8-27, 29 Aug 50, C-1: Medical Collecting Company, Separate
 T/O&E 8-22, 29 Aug 50, C-1: Headquarters and Headquarters Detachment, Medical Group
 T/O&E 8-580, 29 Aug 50, C-1: Evacuation Hospital
 T/O&E 8-667, 29 Aug 50, C-1: Army Medical Depot
 T/O&E 8-7 N, 30 Aug 50, C-2: Medical Company, Infantry Regiment
 T/O&E 8-16 N, 30 Aug 50, C-2: Headquarters and Headquarters Company, Medical Battalion
 T/O&E 8-18 N, 30 Aug 50, C-3: Clearing Company, Medical Battalion
 T/O&E 8-26, 30 Aug 50, C-1: Headquarters and Headquarters Detachment, Medical Battalion, Separate
 T/O&E 8-28, 30 Aug 50, C-1: Medical Clearing Company, Separate
 T/O&E 8-317, 30 Aug 50, C-1: Medical Ambulance Company (Separate)
 T/O&E 8-571, 30 Aug 50, C-1: Mobile Army Surgical Hospital (60-Beds)
 T/O&E 8-581, 30 Aug 50, C-1: Evacuation Hospital, Semimobile
 T/O&E 8-37, 31 Aug 50, C-1: Medical Company, Infantry Regiment, Airborne
 T/O&E 8-76 N, 31 Aug 50, C-2: Headquarters and Headquarters Company, Armored Medical Battalion
 T/O&E 8-77 N, 31 Aug 50, C-2: Company, Armored Medical Battalion
 T/O&E 8-117, 8 Sep 50, C-1: Preventive Medicine Company
 T/O&E 8-510, 8 Sep 50, C-1: Field Hospital
 T/O&E 8-551, 8 Sep 50, C-1: General Hospital, 1000-Bed, Communications Zone
 T/O&E 8-564, 8 Sep 50, C-1: Station Hospital, 200-Bed, Communications Zone
 T/O&E 8-566, 8 Sep 50, C-1: Station Hospital 500-Bed, Communications Zone
 T/O&E 8-650, 8 Sep 50, C-1: Medical General Laboratory
 GHQ FEC CIR 51, 5 Oct 50: Marriage of Military and Civilian Personnel

PART IITECHNICAL

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XIII. Routine Hepatitis Treatment - Francis W. Pruitt, Colonel, MC., Consultant, Internal Medicine



At the suggestion of Doctor Garfield G. Duncan, Consultant in Internal Medicine and Metabolic Diseases, Surgeon General's Office, the following plan for the management of hepatitis is published for use in this Command.

1. High protein bland diet with emphasis on palatability and high quality of protein. The diet should consist of protein, 150 grams, carbohydrates, 350 grams, and fat, 100 grams. (2900 calories). Fat to be from nonanimal sources, that is, milk, dairy products, and eggs. Animal fat is to be avoided.
2. Eight (8) oz. of Protein Milk drink to be consumed after each meal. It may be served on a tray. 8 to 10 oz. to be consumed at bedtime. (See formulas on page 10).
3. All of 1 and 2 must be consumed to total 4,000 calories in 24 hours. The staff must be alert to evaluate the food actually consumed by the sickest patients. In these cases the food not eaten must be calculated in grams and the difference between that eaten and 4,000 calories to be given by tube feeding or intravenous glucose. The recommended formulas for tube feeding are those on page 10, either Doctor Duncan's or Pruitt's.

4. Fluids to at least 3,000 cc during acute stage especially. If severely anorexic, give both fluid and glucose (10%) by vein. Avoid normal saline as there is a tendency to fluid accumulation in this disease and thereby an increase in liver size.

In the severely anorexic patients one must be alert for the symptoms of hypoglycemia.

5. Brewer's yeast 5 grams (10 tablets) three times daily.

6. Multivitamin tablets 2 - 3 times daily.

7. Liver extract, 2 cc by deep hypodermic injection daily if edema or ascites is present.

8. Vitamin K (Synkavite) 5 grams by mouth daily where indicated. Vitamin K must always be given with two 5 grain bile salt tablets. This vitamin need not be given unless the prothrombin time is prolonged beyond twenty-five seconds. Large intravenous doses of Vitamin K are sometimes effective where oral dosage is ineffective.

9. Choline chloride, 1.5 grams daily, dissolved in about 15 cc or more of water. Methionine in milk provides the cystine necessary for choline to be effective. Present evidence indicates these lipotropic substances are most effective early in the disease rather than during the defervescent stage.

10. Bed rest with B.R.P. for bowel movements, until directed otherwise by the doctor.

11. Sedatives: No morphine or barbiturates. Paraldehyde, 4 - 8 cc, hyoscine or chloral hydrate.

12. On this regime, particularly if the illness has been a protracted one, there may be considerable weight gain on the part of the patient. No attempt at weight reduction should be instituted under six months from the date of the release from the hospital.

13. Criteria for ambulation, ¹ as modified:

- a. At least three weeks bed rest.
- b. No hepatomegaly or liver tenderness. Return of appetite and weight gain.
- c. Absence of symptoms, especially lassitude, diarrhea, intestinal cramps, flatus, or headache.
- d. Normal serum bilirubin for one week, if slightly elevated the direct Van den Bergh must be negative.
- e. Bromsulfalein under 5%.
- f. Cephalen flocculation negative in 48 hours.

If one of the above is positive, (except f.), keep in bed one additional week.

Ambulation: One hour twice daily, increasing one hour daily until full ambulation at the end of one week. Post icteric liver function tests to be repeated at this time. If normal, one week of full ambulation with passes and repeated function tests before discharge. If normal tests discharge with instructions for the future.

¹ Capps, R. B. and M. H. Barker. The Management of Infectious Hepatitis. Annals of Internal Medicine, Vol 26 - June, 1947, pg 405.

PRUITT'S PROTEIN MILK FORMULA

Milk	6 quarts
Eggs	24
Ice Cream	4 quarts

Casein, ice cream and one quart of milk are mixed together to form a smooth paste. Lumps of casein must be removed at first mixing.

Then the remainder of milk and eggs are added in a mechanical mixer at slow speed. Chocolate may be used for variety.

Additional sweetening should not be added as it tends to reduce appetite for regular meals.

Usual administration: 8 ounces midmorning and midafternoon; 12 ounces at bedtime.

Generally, patients prefer the drink after it has been chilled in the refrigerator.

One 8-ounce glass = approximately 28 grams of protein and 343 calories.

DUNCAN'S DIET FORMULA

Formula:	P 150	600	Salt Free
	F 144	1296	
	C 400	1600	
		3496 Calories	

Ingredients:

Lonalac Powder *	2 1/8 cups
Water	3 1/3 cups
Powdered Eggs	1 cup
Honey	1 cup
Cream	3/4 cup
Proteinum	3 Tablespoons
Brewer's Yeast Powder	6 Tablespoons

Household Measure:

* Powdered skim milk can be used to replace Lonalac when salt may be included in diet.

XIV. Medical Evaluation of the Non-effective Officer - Colonel Albert J. Glass, Consultant in Psychiatry, Medical Section, GHQ, FEC



The recent campaign in Korea has brought into prominence the not infrequent practice of using medical facilities to remove non-effective officer personnel from their units. This does not refer to the disabled officer suffering from organic or psychiatric illness, but rather to those individuals who displace or blame their inability to perform stressful duty on to bodily or psychiatric symptoms. Such officers verbalize the normal disagreeable physical and psychial sensations of combat, which for them become exaggerated to an illness. They complain of backache, headache, insomnia, gastrointestinal disturbances, nervousness, and anxiety. Some frankly state that they cannot function in combat, but are excellent in other assignments. The non-effective officer is conspicuous by his failure to demonstrate the emotional stability and capability of a combat leader, and is in sharp contrast to the officer psychiatric casualty who has performed effectively in combat prior to a severe battle episode which caused his breakdown.

The basic cause of non-effectiveness in combat for any individual may vary from a conscious unwillingness to unconscious personality defects which prevent or limit his adjustability to any unusual or difficult situation. Almost anyone may become temporarily disorganized under severe stress, but soon the ability of the personality to adjust makes itself manifest and a learning process develops. Most non-effective officers are incapable of making the necessary adjustment and it is evident that such individuals do not possess the necessary qualities of a combat leader.

The medical officer is usually confronted with this problem because the non-effective officer either personally seeks medical evacuation or is sent to the medical officer by his immediate superior. Often in the heat of combat and with the necessary limitation of time a correct evaluation of such an individual cannot be made, and he must be further evacuated to the next medical echelon. Too often the individual continues to be evacuated even out of the theater of operations where his symptoms subside and he is returned to non-combat duty. Such hasty evacuation lowers the morale of officers who continue to perform their hazardous duties and gives the impression that failure is rewarded, with the implication that the Medical Department is responsible. A correct and fair solution of this problem would be to expedite a reasonable evaluation of such cases, preferably near the location

of their origin. In combat divisions the medical officers of the Clearing Company, including the division psychiatrist, should be able to arrive at a correct diagnosis. For other units, nearby evacuation hospitals should be utilized. Only rarely should there be cases which require extensive study and further evacuation.

In considering the diagnosis of non-effective officers primary importance should be given to motivation, previous military performance, and personality inventory of the subject. It is obvious that the officer who consciously displays poor motivation is not sick or disabled. The subject who has performed in a mediocre or indifferent manner in the past usually cannot be expected to do better under more stressful situations. There are many officers who have done good or excellent work in previous non-combat assignments. The personality of these non-effective officers reveal excessive basic insecurity which is compensated for by various character traits. Such individuals may be overly dependent, overly passive, overly cautious, or overly aggressive. These character traits may serve them well in most routine jobs, but in combat or other unusual circumstances the neurotic defense against fear fails and because they have no further resources they become overwhelmed with anxiety and are literally incapable of effective action.

The duty of the medical officer in the case of the ineffective officer is clear and unequivocal. If, after evaluation, the medical officer can find no disabling organic or psychiatric disease the officer must be returned to duty. The diagnosis may be, "No disease, poor motivation", or any of the character or behavior disorders as outlined in SR 40-1015-2. A copy of the findings should be sent to the patient's unit commander. The further handling or disposition of the non-effective officer should be along administrative lines under the provisions of AR 605-200. This regulation provides for the separation, demotion, or elimination of non-effective officer personnel. Pertinent excerpts from paragraph 4 of AR 605-200, stating the reasons for the utilization of this regulation are as follows:

- "Demonstrated inability to exercise the necessary leadership or command required of an officer of his grade."
- "Habitual intemperance or recurrent instances of other personal misconduct."
- "Apathy, defective attitudes, or other character and behavior disorders to include inability or unwillingness to expend effort. Attention is directed to SR 40-1025-2."

This may seem to be a harsh policy but in reality it only corrects an administrative error. No one is forced to accept a commission and when an officer does not possess the required qualifications, corrective, not punitive, measures are indicated. There may be instances where the medical officer may be urged to evacuate non-effective officers under the guise that there is no time for administrative action, or a replacement is immediately needed, or a feeling of pity for the individual. It is important to note that the morale and the very lives of soldiers depend upon the effectiveness of their officers. The medical officer should resist such pressure since the perpetuation of a group of ineffective officers is a serious mistake.

What has been stated above applies with equal force to routine military practice, whether it be in occupation duties or in the zone of the interior. Many officers promptly break down after overseas assignment or when sent to some less desirable post. Here too they show limited ability to adjust to a relatively mild environmental discomfort. This maladjustment may be manifested by symptoms, excess alcoholism, or acts of misconduct. Where no disease is present such cases properly come under administrative procedure, as outlined in AR 605-200 rather than handling through medical channels. The non-effective officer cannot be considered ill since he loses all symptoms when the external situation is altered to his satisfaction. It is rather an immature reaction to adult responsibility. It may well be that transfer to another assignment or location is indicated, but this is an administrative and not a medical matter.

CONCLUSION: A most important factor affecting the fighting strength of our armed forces resides in the effectiveness of our officer personnel. Non-effective officers who are not disabled by organic or psychiatric disease, but who do not possess motivation or qualities required by an officer should not be removed from their units via medical facilities. It is the function of the medical officer to insist that such non-effective officer personnel be handled through administrative channels, under provisions of AR 605-200.

XV. Influenza

Each year with the onset of the so-called "respiratory disease season", the possibility of the occurrence of epidemic influenza must be borne in mind. During this season in 1947 Influenza A was shown to be responsible, in part at least, for a considerable increase in respiratory infections. In the early months of 1950 the presence of Influenza B was demonstrated among occupation personnel in Japan. This infection while apparently the cause of scattered but quite limited increases in respiratory disease incidence did not result in a true influenza epidemic. The highest rate for common respiratory disease and influenza in Japan during that period was experienced in February when the combined rate for these infections among Army and Air Force personnel was 117 per 1000 per annum. The previous month's rate had been 114 and in March the incidence decreased to 101 per 1000 per annum.

The presence of epidemic influenza must be considered if there is a significant rise in the incidence of respiratory infections with symptoms and signs consistent with those commonly associated with influenza.

In non-epidemic periods and in the early phases of an outbreak the clinical diagnosis of influenza is not properly made without substantiating laboratory evidence. Such laboratory confirmation of the specific presence of influenza is primarily of epidemiologic importance to local units in the immediate area of first appearance. Such knowledge is also of value to the Major Command and Theater Surgeon, and is immediately reported to the Influenza Commission of the World Health Organization by the Surgeon General.

The test consists of measuring the increase of antibodies formed in the patient. Such antibodies are capable of inhibiting the agglutination of chicken red blood cells by known influenza virus strains. This determination requires comparison of serum collected early in the disease (as soon after onset as possible) with a specimen collected between the tenth and fourteenth day after onset of the illness. These paired serum specimens are tested simultaneously against 3 well established virus strains known as Influenza A (PR-8), Influenza A' (FM-1), and Influenza B (Lee). Usually the infecting influenza strain will elicit specific antibody response to one of these specific strains of virus. Stimulation of antibodies to related strains are of lesser degree. Comparing the antibody response in the paired serum specimen, a 4-fold (2 tube) or greater increase in titer is considered of diagnostic significance.

The 406th Medical General Laboratory maintains facilities for performance of this laboratory test, and in each new outbreak of suspected influenza in units of battalion or separate company size, or larger, an effort should be made to obtain paired blood specimens from at least 10 suspect cases. Specimens should consist of a minimum of 10 cc of whole blood placed aseptically into a screw-cap tube, or a stoppered and sealed test tube. Each specimen should be forwarded as soon as possible after collection to the 406th Medical General Laboratory, APO 500, by the most expeditious means practicable. They should be accompanied by appropriate laboratory slips presenting the patient's name, rank, serial number, organization, name of submitting institution, suspected diagnosis, date of onset of illness, and date of collection of specimens. The subsequent member of such paired specimens should be prominently labeled "Second Specimen".

Although less desirable, a diagnosis of the etiology of an epidemic can frequently be made by comparing serum from 10 acute cases with serum specimens from an equal number of convalescents. Such groups of sera must be clearly labeled, and accompanied by separate lists identifying specimens by name, date of onset of disease, and date of collection. If no subsequent specimens are to be submitted on the acute cases of such groups, accompanying papers should make this point clear.

Suspected or proven outbreaks of influenza should be reported immediately to the Chief Surgeon, Far East Command. Reports Control Symbol MED-16 applies.

XVI. Case Report of War Casualty: Management of a Shattering Wound to the Lower Jaw - 1st Lt Robert B. Mattes, DC, 376th Station Hospital, APO 323



Pre-Admission History:

Pvt, RA, Age 20, Race White, Sex Male, Height 6 ft, Weight 153 lbs. This 20 year old white male was wounded in action while engaging the enemy in combat at

Masan, Korea, on 15 August 1950. The patient received his wound from a bullet and remained unaided for approximately 6 to 8 hours. He was first seen at a battalion aid station approximately 10 hours after his initial wound where emergency treatment was rendered for the control of hemorrhage and the prevention of pain. The wound he received involved the lower face. He was then evacuated to Pusan, Korea, where no treatment was rendered. From the evacuation hospital at Pusan the patient was air-lifted to the 118th Station Hospital, Japan. A diagnosis was made at this installation of fracture of mandible compound, comminuted, at the symphysis, plus a gun shot wound of the lip. Intermediate treatment consisting of tetanus antitoxin, penicillin, 300,000 units was administered. Surgical intervention was attempted in the form of immobilization of the fractured parts by wire, using the adjacent teeth to the line of fracture for support. The patient was then evacuated by air to the 376th Station Hospital, 36 hours after his initial injury.

Admission Notes:

The patient was admitted to the section of dentistry on the surgical service. He was examined immediately, and the following was noted:

1. Edema of the anterior mandibular area at the symphysis was marked.
2. There was a lacerating wound, through and through, involving the vermillion portion of the lip and skin of the chin in left lateral position to the mid-line. The patient appeared moderately uncomfortable, but in no obvious pain. On intraoral examination, the following was noted:

- a. There was free movement of both segments of the mandible.
- b. There was a through and through break of both skin and mucosa from the mucobuccal fold adjacent to the wound of the lip and chin and extending to the mylohyoid muscle on the lingual aspect of the mandible.
- c. The left central and lateral incisor teeth were missing without evidence of fragmentation.
- d. The remaining oral tissues appeared normal.

Radiographic examination revealed:

1. A compound comminuted fracture of the mandible at the symphysis.
2. Multiple metallic foreign bodies were seen in the area.
3. Multiple fragments of teeth in and about the fracture site.
4. No other injury was revealed by x-ray.

Impression:

This patient was moderately ill, and had sustained a compound comminuted fracture of his mandible at the symphysis with the loss of two teeth, and the deforming property of a lacerating tear from the mylohyoid muscle to the skin. No debridement had been accomplished at the wound site and there was some degree of bone loss at the fracture site. It was decided to operate at once, and routine laboratory work was ordered.

Treatment Progress: Operation Notes:

Two days after his initial injury, the patient had been pre-medicated with .016 grams of morphine sulfate, .0004 grams of scopolamine, and .0004 grams of atropine. His wound was draped in the prescribed manner and a 2% solution of procaine with epinephrine 1:50,000 was used to effect a bilateral mandibular block; peripheral tissues to the fracture site were infiltrated generously. The maxillary tissues were generously infiltrated and a Rison Arch Bar was adapted and wired to the upper arch. A buccal incision was made from the distal aspect of the cuspid teeth on either side of the fracture site, and the flap with its periosteum was reflected downward as far as the inferior border of the mandible. A complete debridement was then accomplished in the usual manner, and multiple fragments of teeth, bone, and metal were removed. The free ends of the fractured segments were then freshened with suitable files and thorough irrigation of the area was accomplished with normal saline solution. A Rison Arch Bar was adapted and wired to the mandible by means of which the fractured segments were brought into correct position and immobilized. The mandible was immobilized to the maxilla by means of interdental rubber ligatures. Interrupted black 00 silk sutures were used to replace and close the intraoral flap. Absorbable 00 catgut was used for subcutaneous closure of the lip, and 000 black silk interrupted sutures were placed in the skin and

vermillion portion of the lip. A strip of vaseline gauze was then adapted over the external wound, and 4 x 4 dressings, as compresses, were placed. The patient was returned to his room in good condition with the following accompanying orders:

1. Nothing by mouth for 24 hours.
2. Five percent glucose in saline IV 1000 cc STAT.
3. Elevate and immobilize head STAT.
4. Sodium amytal .120 grams STAT.
5. Procaine penicillin, 300,000 units daily.
6. High vitamin, high caloric liquid diet with intermittent nourishment.
7. Codeine grams .060 q 4 h PRN.
8. Bi-weekly weight chart.
9. Daily white blood count and urine analysis.

Post-Operative Notes:

The patient was seen the first post-operative day, and it was reported that he had an entirely uneventful night. There was no pain, a reasonable amount of edema, no respiratory embarrassment, and no elevation of temperature. The patient said he felt well. Both AP and PA radiograms were ordered, and narcotics were discontinued. It was decided to continue present penicillin therapy. The patient was seen on the second post-operative day, and it was noted that the edema was diminishing in extent. The external bandages were removed and the incision was progressing well. Intraoral granulation was noted and the fracture parts remained immobile. Post-operative x-rays revealed a satisfactory reduction and the absence of foreign bodies. Fragments were in good position and alignment. There was some degree of bone loss revealed at the symphysis. The patient was allowed to be up as desired. On the third post-operative day, the patient was seen in the Dental Clinic. Skin sutures and intraoral mucosal sutures were removed. Intraoral tissues were granulating and the skin was closed completely. Intraoral irrigation with 50% solution of peroxide and saline was ordered every two hours. From the 4th to the 28th post-operative day, the patient was seen daily in the Dental Clinic, where minor adjustments of the intraoral appliances were made. At that time, the mouth was thoroughly irrigated with a 50% solution of peroxide and saline. There were no significant changes in the initial therapy and penicillin was continued throughout the period. Periodic radiograms were obtained and beginning callus formation was noted throughout the period. On the 29th post-operative day the patient was seen in the Dental Clinic, and the intraoral appliances were removed. It was noted that the teeth adjacent to the fracture site were mobile, but that the occlusion was excellent. On the 30th post-operative day, one day after the removal of the intraoral appliances, it was noted that the occlusion was not in the same position as it was the day previous. It was felt at this time that because of the large amount of bone loss, that the tension of the mylohyoid muscle was depressing the fracture segments lingually. After consultation with the Prosthodontist it was decided to correct this by means of a combination splint and partial denture. An impression was taken; a model poured (Fig. 1). The model was corrected by cutting it in two parts and adjusting the occlusion to the intact maxillary arch (Fig. 2). The new appliance was then constructed. The patient was seen the next day in the



FIG 1



FIG 2

prosthetic department. The two mobile teeth were extracted and the combination splint-partial denture (Immediate) was placed (Figs. 3, 4, 5). The patient was seen daily and put on a regular diet



FIG 3



FIG 4



FIG 5

for a period of ten days. He had complete function of his masticating apparatus, and an excellent prognosis for complete union and subsequent ossification (Figs. 6, 7). The patient was discharged and sent back to duty 41 days after his initial injury.



FIG 6

Summary and Conclusion:

In summing up this case, it should be noted that there was not sufficient loss of bone at the symphysis to warrant grafting of bone from other body parts. It was decided that since function of the mandible had been completely restored, ultimate callus formation and subsequent ossification would occur.

This dramatically illustrates the ease with which certain war casualties can be returned to full active duty status before total union of a fractured mandibular bone is effected.



FIG 7

XVII. A Comparison of Triton-NE with QM Laundry Detergent As Suggested for the AMS III Technique - Col G. W. Hunter III, MSC, L. S. Ritchie, K. Patterson and L. L. Muniz, Department of Medical Zoology, 406th Medical General Laboratory, Tokyo, Japan.

INTRODUCTION:

The addition of Triton-NE* to the acid-ether concentration technique of Telemann (1908) for the recovery of the eggs of Schistosoma mansoni was first reported by Weller and Dammia (1945a). Its usefulness for the recovery of the eggs of S. japonicum was reported by Hunter, Ingalls and Cohen (1945, 1946) and the use of Triton-NE was incorporated into the acid sodium sulphate-ether procedures known as the AMS techniques as devised by Hunter et al (1945, 1946, 1948). The last modification, termed the AMS III, was found to be excellent for the recovery of eggs of S. japonicum as well as other helminths. Muschel (1949) reported good results in the recovery of schistosome eggs from the stool by substituting a 10% aqueous solution of mobile laundry detergent (QM item 51-D-175) for the less readily obtainable Triton-NE. Since the AMS III is used routinely in our epidemiological surveys for the recovery of helminth eggs and larvae, it was decided to run a series of comparative tests between Triton-NE and laundry detergent.

MATERIALS AND METHODS:

Stools containing as many different kinds of parasites as possible were selected for these tests. Although most of the comparisons that were made utilized fresh stools, a small series using preserved specimens was also run.

The following procedure was utilized:

1. Eight (8) grams of fresh feces were weighed out, comminuted thoroughly in 24 ml. of water and filtered through two layers of moist gauze.
2. Four (4) ml. of this mixture were transferred to each of four 15 ml. graduated centrifuge tubes, mixing well before pipetting each sample (each tube contained approximately 1 gr. of feces).
3. The tubes were then centrifuged for two minutes at 1700-2100 RPM and the supernate decanted.
4. Five (5) ml. of HCl-Na₂SO₄ solution were added, mixed well, centrifuged for two minutes at 1700-2100 RPM and the supernate decanted.
5. Step #4 repeated.
6. Five (5) ml. of the HCl-Na₂SO₄ solution were added to all tubes, then three drops of Triton-NE to two tubes and six drops of the QM detergent to the other two. (The difference in the number of drops applied was due to the differences in viscosity between the two.) They were then mixed thoroughly with an applicator stick, 5 ml. of ether added, shaken vigorously and centrifuged at 1700-2100 RPM for two minutes.
7. With the aid of a bulb pipette the supernate was removed to the 1 ml. mark.
8. The sediment was thoroughly mixed with the remaining liquid, a 0.05 ml. sample removed and examined under a 22 x 40 mm. cover slip. All types of eggs were counted and recorded.
9. The results of the two counts with each technique were then averaged and the average counts used for comparison.

DISCUSSION OF RESULTS:

The results secured on the same stool samples using both Triton-NE and the QM laundry detergent are summarized in Table I, shown on Page 18. A total of 61 fresh and 15 preserved stool specimens were tested. Forty-nine (49) of the fresh stools yielded more eggs of Schistosoma japonicum with Triton-NE while two gave better results with the QM detergent. A total of 309 schistosome eggs were recovered by the use of Triton-NE while only 49 were found when the QM detergent was substituted. In the case of Ascaris lumbricoides, Trichuris trichiura and hookworm, the use of Triton-NE resulted in more eggs being recovered in 71 to 95% of the cases. Furthermore, the total number of eggs recovered definitely favored the use of Triton-NE (Table I). Only in the case of Trichostrongylus sp. were the Triton-NE and the QM detergent nearly equal.

Fifteen (15) preserved stools were tested. In only one instance did the QM detergent recover more eggs than the Triton-NE. In all other cases the total number of eggs recovered was markedly higher when Triton-NE was utilized (Table I). This clearly demonstrates the greater efficacy of the Triton-NE as compared to the QM detergent in recovering eggs of S. japonicum as well as those of other helminths.

* May be secured at a nominal cost from Rohn and Hass Co., Philadelphia, Pa.

TABLE I

COMPARISON OF THE RESULTS OBTAINED USING TRITON-NE AND QM LAUNDRY DETERGENT IN THE AMS III TECHNIQUE
TESTS ON 61 FRESH STOOLS

Helminths	No. of Times Triton-NE Recovered More Eggs	No. of Times Laundry Detergent Recovered More Eggs	No. of Times Same Recovery by Both Techniques	Total No. Eggs Recovered with Triton-NE	Total No. Eggs Recovered with Laundry Detergent
<i>Schistosoma japonicum</i>	49	2	3	309	49
<i>Ascaris</i>	38	11	0	1354	530
<i>Trichuris trichiura</i>	55	4	2	2610	1863
Hookworm	36	2	0	238	42
<i>Trichostrongylus</i> sp.	4	3	3	7	5
Pinworm	2	0	0	2	0

TESTS ON 15 PRESERVED STOOLS

<i>Schistosoma japonicum</i>	12	0	0	37	5
<i>Ascaris</i>	15	0	0	1001	113
<i>Trichuris trichiura</i>	15	0	0	338	42
Hookworm	12	1	0	63	6
<i>Trichostrongylus</i> sp.	3	0	0	3	0
<i>Clonorchis sinensis</i>	1	0	0	160	69
<i>Paragonimus westermani</i>	1	0	0	4	1

Our findings appear to be supported by the combined reports of Weller and Dammin (1945 and 1945a) and Most et al (1950). The former presented the Acid-Ether technique without the use of a detergent (1945) and subsequently introduced Triton-NE (1945a) with greatly improved results. On the other hand, Most et al (apparently working before the latter report was available) combined laundry detergent with the initial technique of Weller and Dammin, but without getting improved results. To be sure, there is a basic difference in the AMS III and the Acid-Ether technique, namely the use of sodium sulphate.

SUMMARY:

The results obtained in the comparison of Triton-NE with QM laundry detergent (#51-D-175) clearly demonstrate the superiority of the Triton-NE in the recovery of the eggs of *S. japonicum*, *A. lumbricoides*, *T. trichiura* and hookworm. It is better for the eggs of *Trichostrongylus* sp., *Clonorchis sinensis*, *Paragonimus westermani* as well as the others mentioned above when preserved stools are tested. On the basis of these findings, the continued use of Triton-NE for the AMS III technique is recommended.

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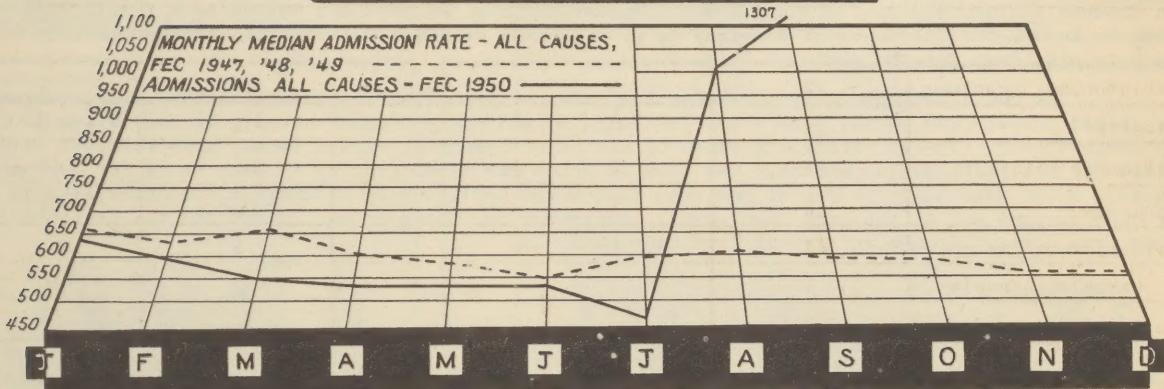
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PART III - STATISTICAL**HEALTH OF THE COMMAND**

Admission rates per 1000 troops per annum for the five-week period ending 29 September 1950 were as follows:

	<u>FEC</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILCOM(AF)</u>	<u>RYCOM</u>
All Causes	1307	539	2337	304	349	670
Diseases	725	476	1058	233	285	616
Injuries	125	62	213	71	64	54
Battle Casualties	456	.13	1066	0	0	0
Psychiatric	56	15	115	3.9	8.6	6.9
Common Respiratory Diseases and Flu	52	32	46	48	33	156
Primary Atypical Pneumonia	2.0	2.0	1.5	1.3	0	5.2
Common Diarrhea	43	3.5	91	0	1.4	19
Bacillary Dysentery	.19	.25	.11	0	0	.43
Amebic Dysentery	.34	.25	.23	0	4.3	0
Malaria, new	14	4.0	29	0	1.4	1.3
Infectious Hepatitis	3.9	4.3	4.6	0	7.2	.43
Mycotic Dermatoses	4.7	.33	10	0	0	.43
Rheumatic Fever	.39	.50	.23	0	1.4	.43
Venereal Diseases	96	145	33	13	60	205

The data submitted in this report for the FEC for September is complete for all commands. Data pertaining to Korea for this month includes all Army personnel of both Eighth Army and X Corps as well as all Air Force personnel in Korea.

ADMISSION RATES:

In September the rate of admissions to hospitals, quarters and dispensaries for all causes among Army and Air Force personnel of the FEC increased from 959 per 1000 per annum in August to 1307. This increase is attributed entirely to Korea. The other commands did experience minor increases; however, their rates were all below the FEC rates for the previous month.

The disease component of the all causes rate increased from 663 in August to 725 for September. Japan and Korea had minor decreases in their disease rate while RYCOM, PHILCOM (AF) and MARBO showed slight increases. In view of the comparatively low rates experienced by PHILCOM (AF) and MARBO, their slight increases this month are not considered significant. The increase in rate for the FEC results entirely from the Korean rate. Although Korea experienced a decrease from 1096 in August to 1058 for September, their mean strength for the period increased to the extent that it is a dominating factor and thereby greatly influences the FEC rate.

The nonbattle injury component of the all causes rate increased from 83 to 125. Here again the rise in rate is attributed to Korea whose rate increased from 164 in August to 213 for this month. Among the other major commands, all except RYCOM had increases in this component of the total admission rate; however, their rates remain within the realm of previous experience.

The battle casualty admission rate for the FEC was 456 for September as compared to 212 for August. For Korea alone this rate was 1066 per 1000 per annum as compared to 693 in August. Although the disease incidence rate for the FEC has increased during the past two months as a result of troops being in Korea, the incidence of diseases is nevertheless considered favorable, and indications are that the rate will drop for the month of October.

The FEC's average daily non-effective rate for September represents another sharp increase for the second consecutive month. The rates for July, August and September are 17, 32 and 44 per 1000 per day respectively. The non-effective rates of the major commands, except Japan, have remained rather static for the past several months. The rate in Japan has risen from 13 in June to 84 for September. The very short evacuation policy of patients from Korea continues to maintain a low non-effective rate for that theater and at the same time greatly increases the Japan rate. Except for the patients in Japan from Korea, Japan's rate would have been about 15.

DISEASES:

Common Respiratory Diseases and Influenza: As might be expected, there was an increase in the CRD and influenza rate for the FEC for September. The rate for September was 52 as compared to 42 for August. Except Japan, all major commands reported an increase in the incidence of these diseases for the month. It is noted with interest that in RYCOM during September, the CRD and influenza rate among Air Force personnel was 231 as compared to 58 for Army personnel. The major commands' rates for this period are as follows: Japan 32, Korea 46, MARBO 48, PHILCOM (AF) 33 and RYCOM 156.

Psychiatric: A marked decrease in the psychiatric rate from 88 in August to 56 in September for the FEC was noted. This decrease is attributed to Korea's sharp decrease from 258 for the preceding month to 115 for September. The other commands had no notable changes and remain comparable to past experiences for these conditions.

Malaria: The September rate for new malaria in FEC depicts a small decrease from 15 in August to 14. Approximately 87% of all malaria for the month occurred among personnel either in Korea or recently evacuated therefrom. The rate for Korea was 29 as compared to 31 for the preceding month. MARBO reported no cases and PHILCOM (AF) only one. Until August of this year, RYCOM had had only 1 case. During August, they reported another case, and 3 more for September. The incidence of malaria in RYCOM has been extremely favorable for the year when compared to previous experience. Japan's rate of 4 for September is about the same as reported in August.

Common Diarrhea and Dysentery: The incidence of intestinal diseases infections increased in the FEC from a rate of 42 per 1000 per annum in August to 51 for September. The following rates were experienced by the major commands for August and September respectively: Japan 9.5 and 4.8; Korea 115 and 109; MARBO 0 and 0; PHILCOM (AF) 1.9 and 5.7; RYCOM 19 and 20.

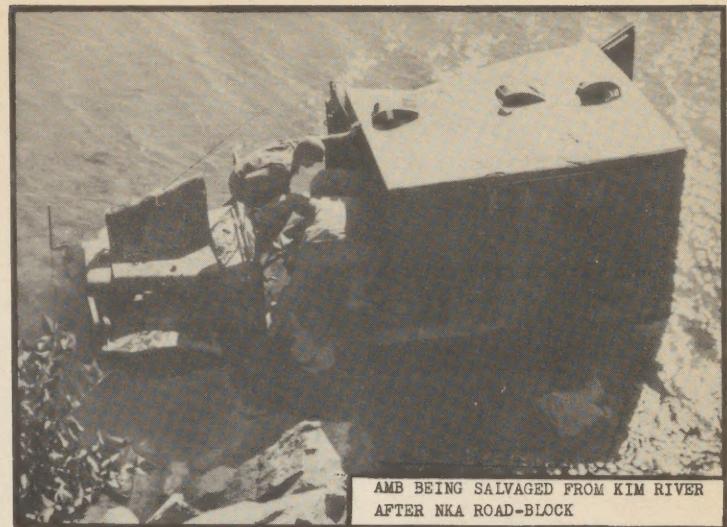
Poliomyelitis: 10 cases of poliomyelitis were reported in the FEC during September. Of these cases, 6 occurred in Japan, 2 in Korea and 2 in MARBO. These are total cases occurring among all occupation personnel and bring to a total of 65 cases with 2 deaths resulting for the FEC for the year.

Encephalitis: For the year through September, and among all occupation personnel, there have been 292 cases of encephalitis reported with 18 deaths resulting. 253 cases with 13 deaths resulting occurred in Korea. 25 cases with 5 deaths resulting occurred in Japan. 13 cases with no deaths occurred in RYCOM, and 1 case with no death occurred in MARBO. Of these 292 cases, approximately 100 have been confirmed by the laboratory as Japanese B type.

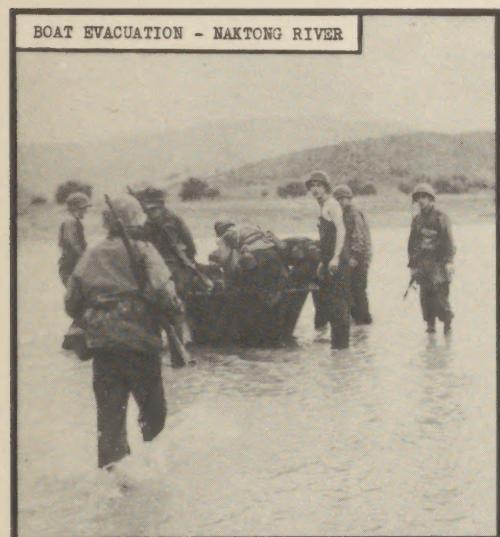
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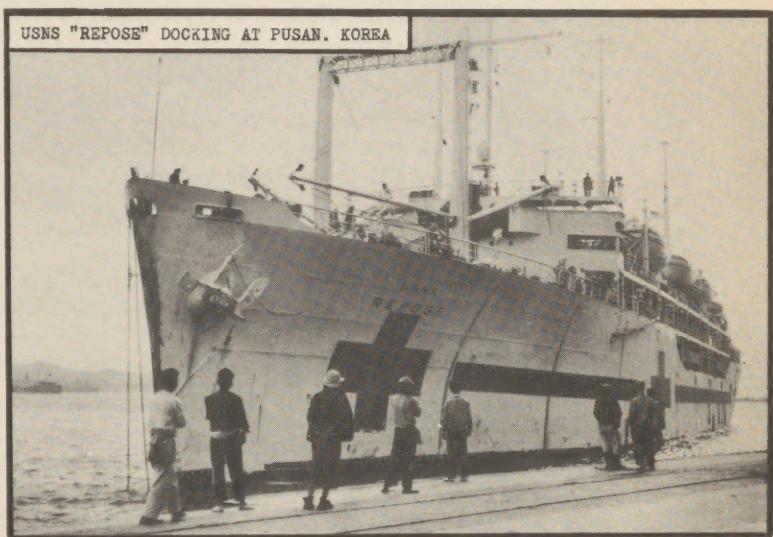
ROK WIA BEING EVACUATED
TO TAEGU, KOREA



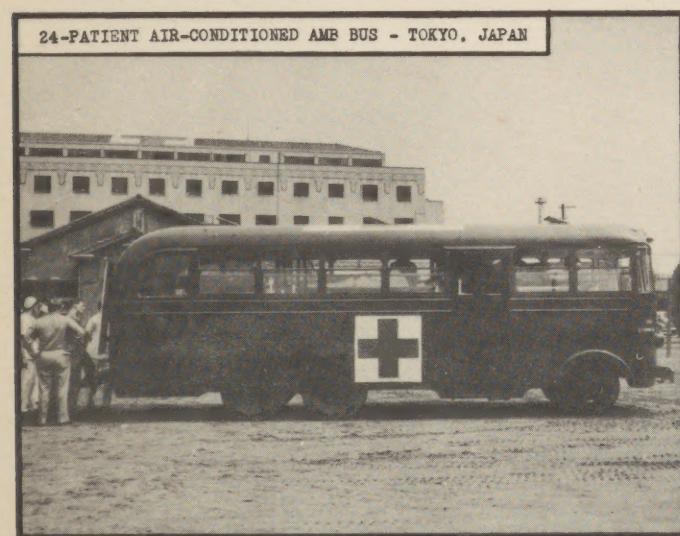
AMB BEING SALVAGED FROM KIM RIVER
AFTER NKA ROAD-BLOCK



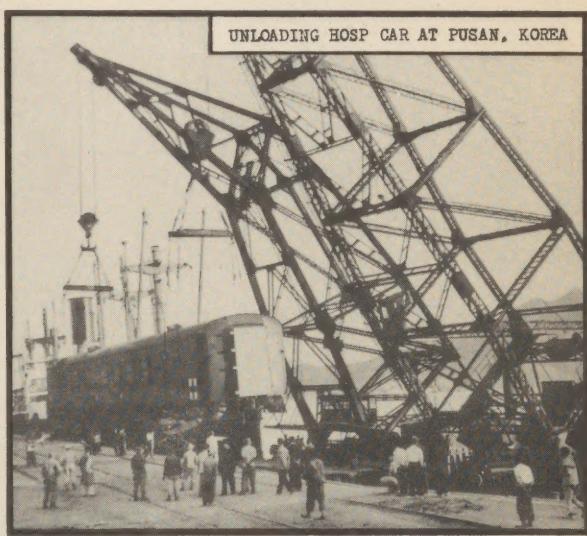
BOAT EVACUATION - NAKTONG RIVER



USNS "REPOSE" DOCKING AT PUSAN, KOREA



24-PATIENT AIR-CONDITIONED AMB BUS - TOKYO, JAPAN



UNLOADING HOSP CAR AT PUSAN, KOREA

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The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Major Vincent I. Hack, Editor